MEDICAL

BINDER

Basic Health Information

First Name: _____ Middle Name: _____ Surname: _____

Date of Birth: _____ Blood Type: _____ Donor: ☐ Yes ☐ No

Allergies

Current Medications	Route/Notes

Emergency Contact Information		
Name	Relationship	Phone Number

All About Me

My Name Is	
I Also Like to Be Called	
My Birthday Is	
My Address Is	
I Live With	
I Communicate By	
My Favorite Things Are	
Things I Do Not Like Are	
Things That Comfort Me When I Am Sad Are	
Things That Help When I Am In Pain Are	

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MEDICAL CONTACTS

DOCTOR:

Specialty:	
Phone:	Email:
Address:	
Fax:	

DOCTOR:

Specialty:	
Phone:	Email:
Address:	
Fax:	

DOCTOR:

Specialty:	
Phone:	Email:
Address:	
Fax:	

DOCTOR:

Specialty:	
Phone:	Email:
Address:	
Fax:	

Allergies and Sensitivities

An **allergy** means your body sees the medicine as harmful. It rejects the drug with an allergic reaction. This can be mild or strong. It can happen within a few hours after you take the drug or not until 2 weeks later. A **sensitivity** or **side effect** is not the same thing as an allergy – it's just your body feeling sensitive to a new medication. Some examples of sensitivities include feeling sick to your stomach, having muscle aches, or not having much energy[3].

Allergy or Sensitivity	What Happens?

[3] Web MD. (2017). *Is it a drug allergy or a side effect?* Available from https://www.webmd.com/allergies/allergy-or-side-effect?print=t

My Medication Information

My Pharmacy	
Name	
Address	
Phone Number	

My Medication Allergies	
Drug	Reaction

My Medications				
Name	Reason	How Much	How Often	Prescriber

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Alternative or Complimentary Therapies

A complementary therapy is something you do or use alongside your conventional medical treatment[5].

An alternative therapy is something you do or use instead of conventional medical treatment[1].

Some examples include: aromatherapy, acupuncture, herbal medicine, massage therapy, visualization, yoga

Description and details of practice:
Description and details of practice:
Description and details of practice:
Description and details of practice:

[5] Cancer Research UK. (2018). The difference between complementary and alternative therapies (CAMS). Retrieved from: https://www.cancerresearchuk.org/about-cancer/cancer-in-general/treatment/complementary-alternative-therapies/about/difference-between-therapies

My Medical Equipment

My Durable Medical Equipment Companies	
Company Name	
Address	
Phone/Email	
Company Name	
Address	
Phone/Email	
Company Name	
Address	
Phone/Email	

My Current Equipment		
Type	DME Company	Date Received

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Personal Health History

Diagnoses		
Year	Name of Diagnosis or Concern	By Who (e.g. physician's name, etc.)?
Any other pertinent information related to diagnosis?		
Year	Name of Diagnosis or Concern	By Who?
Any other pertinent information related to diagnosis?		
Year	Name of Diagnosis or Concern	By Who?
Any other pertinent information related to diagnosis?		
Year	Name of Diagnosis or Concern	By Who?
Any other pertinent information related to diagnosis?		
Year	Name of Diagnosis or Concern	By Who?
Any other pertinent information related to diagnosis?		
Year	Name of Diagnosis or Concern	By Who?
Any other pertinent information related to diagnosis?		

My Surgical History

Surgery	Date of Surgery	Surgeon

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Personal Health History

Hospital Visits		
Year	**Reason**	**Name of Hospital**
		☐ Emergency Department Visit Only ☐ Admitted to Hospital
		☐ Emergency Department Visit Only ☐ Admitted to Hospital
		☐ Emergency Department Visit Only ☐ Admitted to Hospital
		☐ Emergency Department Visit Only ☐ Admitted to Hospital
		☐ Emergency Department Visit Only ☐ Admitted to Hospital
		☐ Emergency Department Visit Only ☐ Admitted to Hospital

Vital Sign Notes

Use this template to record any important details about vital signs.

Vital Signs	Notes
Blood Pressure	
Heart Rate (Beats per minute)	
Respiratory Rate (Breaths/minute)	
Weight	
Pain or Discomfort	
Oxygen Level (Saturation)	
Bowel Movements	

My Neurological System

My Neurological Diagnoses	
My Neurology Team	

My Seizures	
What Do My Seizures Look Like?	
How Often Do I Typically Have Seizures?	

My Daily Seizure Medications

Name	Route	How Much	How Often

My Rescue Seizure Medications

Name	Route	How Much	How Often

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My Neurological System (Page 2)

My Shunt	
My Neurosurgery Team	
My Type of Shunt (VA, VP, etc.)	
Signs My Shunt Has Malfunctioned	

My Spasticity/Tone Dystonia	
My Spasticity Management Team	
My Baseline Muscle Tone	
My Spasticity Management Plan	

My Tone Management Devices

My Tone Management Medications			
Name	Route	How Much	How Often

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My Neurological System (Page 3)

My Autonomic Instability	
My Managing Team	
My Baseline Temperature	
Reason Why Temperature is Out of This Range	
What to Do When Cold	
What to Do When Hot	
My Baseline Heart Rate (HR)	
Reason Why HR is Out of This Range	
What to Do When HR is Below Baseline	
What to Do When HR is Above Baseline	
My Baseline Blood Pressure (BP)	
Reasons Why BP is Out of This Range	
What to Do When BP is High	
What to Do When BP is Low	

When to Call My Managing Team	
When to Seek Emergency Care	

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My Ear, Nose and Throat System

My ENT Diagnoses	
My ENT Team	
My Audiologist	

My Tracheostomy Information	
Trach Size and Type	
Tie Type	
Tube Changing Schedule	
Suction Catheter Size	
Suction Depth	
Trach Care	

My Hearing Device

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My Pulmonary System

My Pulmonary Diagnoses	
My Pulmonary Team	

My Pulmonary Medications			
Name	Route	How Much	How Often

My Pulmonary Clearance Program	
Type	How Often

My Respiratory Support	
Manufacturer/Model	
Supplier	
Settings	
Sick Settings	

My Pulmonary Sick Plan

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My Cardiac System

My Cardiac Diagnoses	
My Cardiology Team	

My Cardiac Medications			
Name	Route	How Much	How Often

My Cardiac Devices

My SBE Prophylaxis Plan

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My Gastrointestinal System

My GI Diagnoses	
My GI Team	
My Nutritionist	

My Feeding Tube Information	
Tube Size	
Tube Manufacturer	
Tube Changing Schedule	
Tube Supplier	
Managing Provider	

My Formula Information	
Formula	
Amount Per Feeding	
Feeding Schedule	
Sick Day Plan	
Pump Rate/Bolus	
Formula Supplier	

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My Gastrointestinal System (Page 2)

My GI Medications			
Name	Route	How Much	How Often

My Nutrition Plan	
I Get My nutrition By	Mouth ◯ NJ ◯ NG ◯ GT ◯ JT ◯ GJT ◯ CVL ◯
My Favorite Foods Are	
Foods I Don't Like Are	
My Food Allergies Are	
My Last Swallow Test Was	
My Special Feeding Instructions Are	

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My Gastrointestinal System (Page 3)

My Bowel Management	
My Typical Bowel Pattern Example: Frequency, Consistency, Amount	

My Colostomy	
Appliance Type	
Changing Schedule	
Stoma Care	

My Cecostomy/Malone	
Tube Size	
Manufacturer	
Tube Changing Schedule	
Tube Supplier	
Flush Regimen	

My Bowel Medications			
Name	Route	How Much	How Often

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My Kidney and Bladder System

My Nephrology/Urology Diagnoses	
My Nephrology Team	
My Urology Team	

My Drains (Ileovesicostomy, Mitrofanoff, Urethral Cath)	
Type/Size	
Cath Schedule	
Flush Schedule	

My Kidney and Bladder Medications

Name	Route	How Much	How Often

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My Musculoskeletal System

My MSK Diagnoses	
My Orthopedic Surgery Team	
My Physical Medicine and Rehab Team	
My Special Precautions	

My MSK Equipment		
Type	Company	Date Received

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My Dermatological System

My Dermatology Diagnoses	
My Dermatology Team	
My Plastic Surgery Team	
My Wound Management Provider	

My Wounds	
Type	
Location	
Care	

Scan for an Eczema Plan developed by NAPNAP's Dermatology Special Interest Group.

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My Endocrine System

My Endocrinology Diagnoses	
My Endocrinology Team	

My Diabetes Monitoring	
Type of Diabetes	
Blood Sugar Goals	
Frequency of Blood Sugar Checks	
Reasons to Call Endocrinology	
Reason to Seek Emergency Care	
Provider of Supplies	

My Diabetes Medications			
Name	Route	How Much	How Often

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My Endocrine System (Page 2)

My Diabetes Insipidus Monitoring	
Sodium Goals	
Frequency of Sodium Checks	
Lab Location	
Urine Output Monitoring	
Reasons to Call Endocrinology	
Reasons to Seek Emergency Care	

My Diabetes Insipidus Medications			
Name	Route	How Much	How Often

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My Endocrine System (Page 3)

My Adrenal Insufficiency Monitoring	
Reasons to Start Providing Illness Dosing	
Reasons to Provide Emergency Dosing	
Reasons to Call Endocrinology	
Reasons to Seek Emergency Care	

My Adrenal Insufficiency Medications				
	Name	Route	How Much	How Often
Physiologic Steroid Dosing				
Illness Dosing				
Emergency Dosing				

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My Mental Health

My Mental Health Diagnoses	
My Psychology Team	
My Psychiatry Team	

My Psychiatric Medications			
Name	Route	How Much	How Often

My Behavior Management Plan

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My Sleep Information

My Sleep Hygiene	
Bedtime Routine	
Comfort Items	
Environment (Example: Lights, Sounds)	
Bedtime	
Wake Time	

My Sleep Aid Medications				
Name	Route	How Much	How Often	Prescriber

My Non-Invasive Positive Pressure Ventilation (NIPPV)	
NIPPV Type (BiPAP vs. CPAP)	
Manufacturer	
Settings	
Interface	
Supplier	
Sleep Medicine Team	

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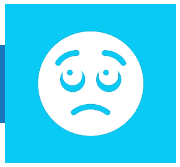
My Pain Management



My Pain Diagnoses	
My Pain Management Team	
My Palliative Care Team	

Common Locations of Pain	
Signs of Pain	
Non-Pharmacological Interventions (Example: Massage, Position)	
Comfort Items	

My Pain Medications			
Name	Route	How Much	How Often

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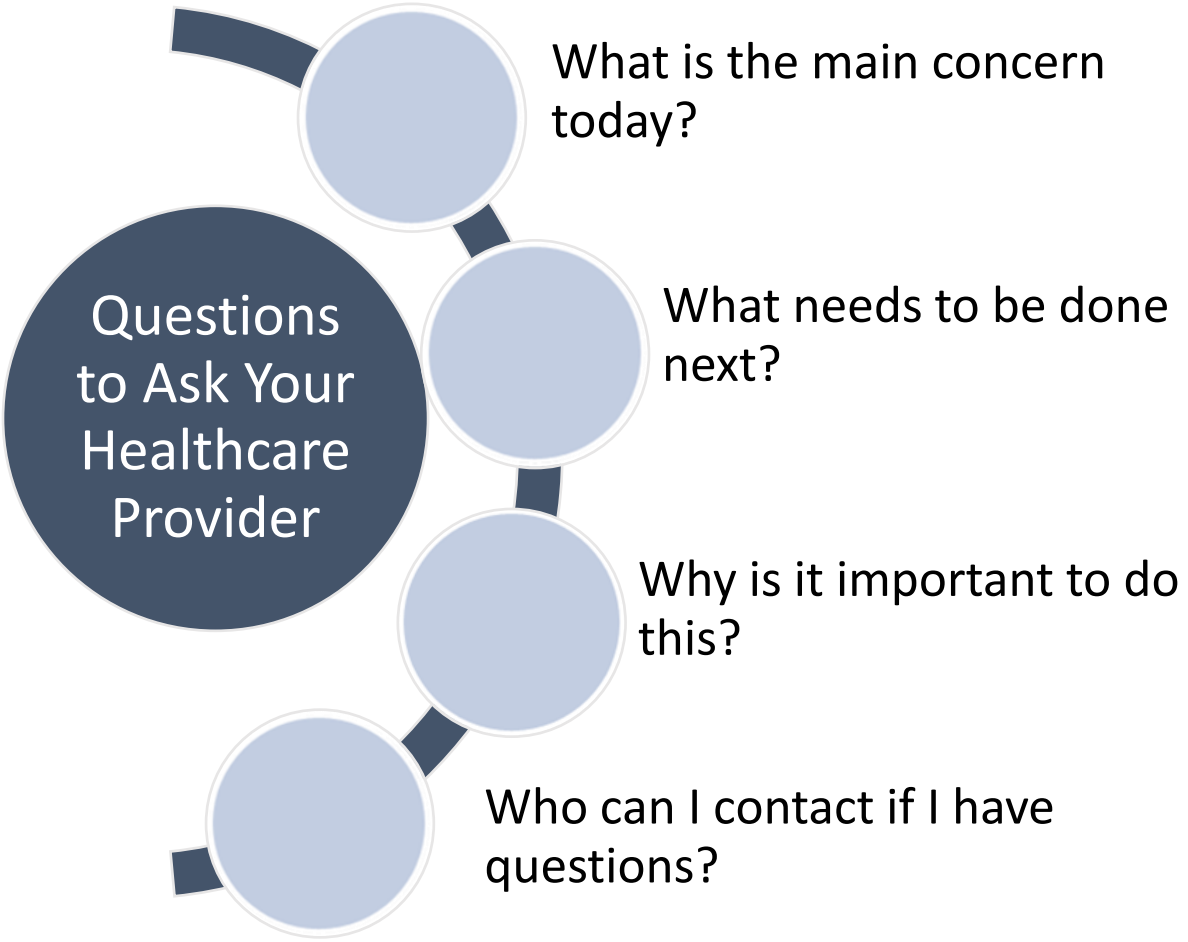
Questions to Ask Healthcare Providers

Caregivers can be **advocates** for the person they care for. Here are **four** questions to consider asking when you interact with healthcare providers.


Questions to Ask Your Healthcare Provider
What is the main concern today?
What needs to be done next?
Why is it important to do this?
Who can I contact if I have questions?

Appointment Tracking Sheet

Appointment Date	Provider Name and specialty	Location
Date: Time:		☐ I asked about parking, cost & map
Reason for Appointment	**Supporting Documents to Bring**	**Notes for Appointment**
Questions to Ask (i.e. what is my main problem today, what do I need to do next, why is it important)		
Next Appointment Date		**Follow up Instructions**
Date: ☐ We book Time: ☐ They book		

Appointment Date	Provider Name and specialty	Location
Date: Time:		☐ I asked about parking, cost & map
Reason for Appointment	**Supporting Documents to Bring**	**Notes for Appointment**
Questions to Ask (i.e. what is my main problem today, what do I need to do next, why is it important)		
Next Appointment Date		**Follow up Instructions**
Date: ☐ We book Time: ☐ They book		

Tests and Procedures

Procedure/Test	Date and Time	Location
	Date:	
Who ordered the procedure/test?	Time:	
		☐ I asked about parking, cost & map

Notes about procedure prep, response, recovery	Questions to Ask

Follow up:

Procedure/Test	Date and Time	Location
	Date:	
Who ordered the procedure/test?	Time:	
		☐ I asked about parking, cost & map

Notes about procedure prep, response, recovery	Questions to Ask

Follow up:

Procedure/Test	Date and Time	Location
	Date:	
Who ordered the procedure/test?	Time:	
		☐ I asked about parking, cost & map

Notes about procedure prep, response, recovery	Questions to Ask

Follow up:

Communication Log

Question(s) For:			
Date:		Time:	
Question(s) or Concern(s):			
Response/Follow up:			
Question(s) For:			
Date:		Time:	
Question(s) or Concern(s):			
Response/Follow-up			

Community Provider Visits

Provider Name and/or Organization		This visit has an additional provider binder in the home ☐ Yes ☐ No
Visit Date & Time:		
Reason for Visit:		
Next Visit Date & Time:		
Notes:		

Provider Name and/or Organization		This visit has an additional provider binder in the home ☐ Yes ☐ No
Visit Date & Time:		
Reason for Visit:		
Next Visit Date & Time:		
Notes:		

Community Provider Log

Date	Provider	Notes about Care Provided	See Message Page
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

Messages I have for Community Providers

To:			
Date:		Time:	
Message:			
Response/Follow up:			

To:			
Date:		Time:	
Message:			
Response/Follow up:			

How Friends and Family Can Help

Task	Who Can Help
e.g. Mowing the Lawn	*e.g. George - Neighbour*

Meal Planning or Tracking Chart

	Monday	Tuesday	Wednesday
Breakfast	☐ Meal Support Time:_____	☐ Meal Support Time:_____	☐ Meal Support Time:_____
Snack	☐ Meal Support Time:_____	☐ Meal Support Time:_____	☐ Meal Support Time:_____
Lunch	☐ Meal Support Time:_____	☐ Meal Support Time:_____	☐ Meal Support Time:_____
Snack	☐ Meal Support Time:_____	☐ Meal Support Time:_____	☐ Meal Support Time:_____
Dinner	☐ Meal Support Time:_____	☐ Meal Support Time:_____	☐ Meal Support Time:_____
Snack	☐ Meal Support Time:_____	☐ Meal Support Time:_____	☐ Meal Support Time:_____

Date Range:

_____

_____

Allergies/Dietary Restrictions:

_____

_____

_____

_____

_____

_____

Preferences or Considerations:

_____

_____

_____

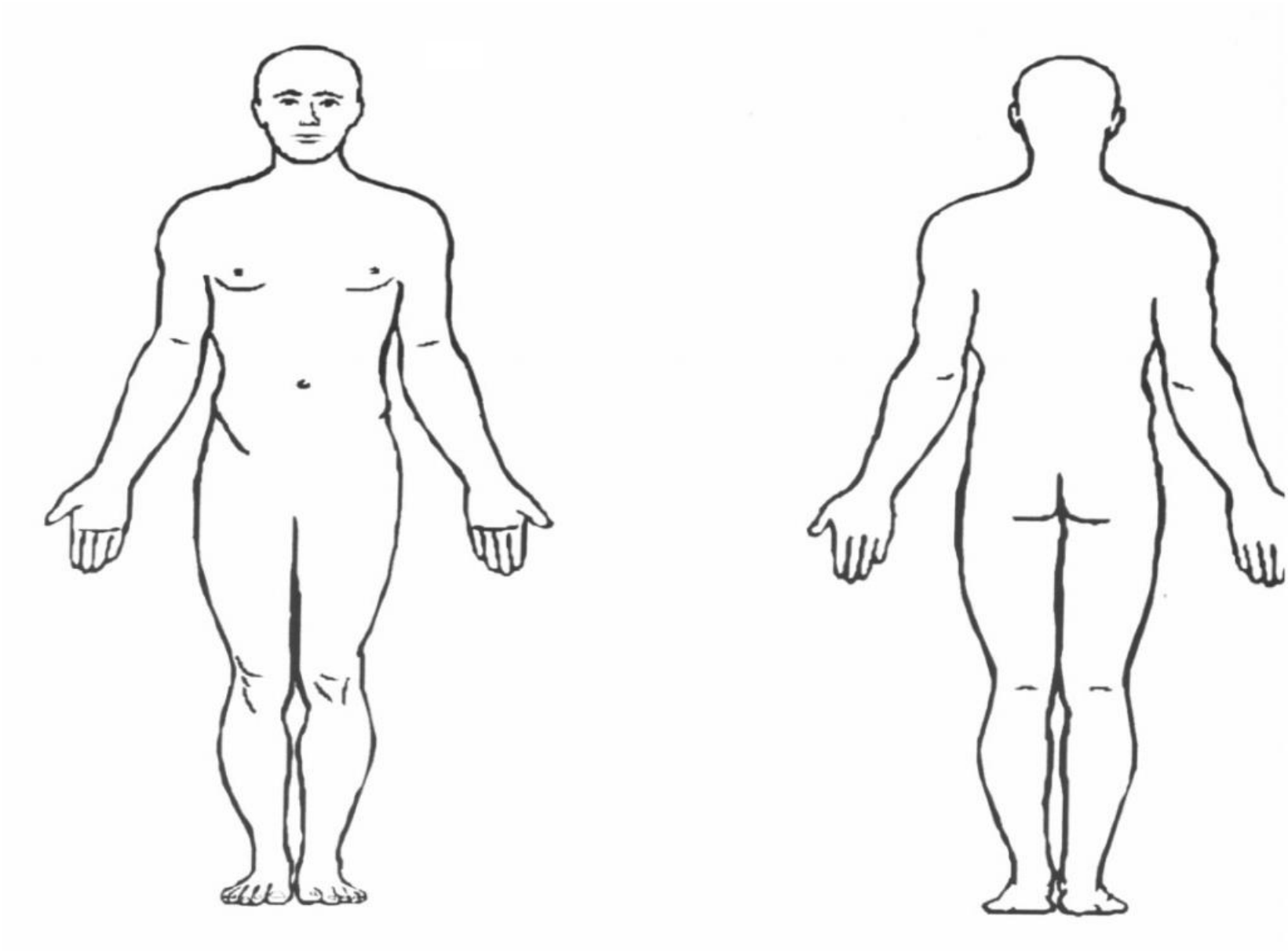
_____

_____

Daily Routines

For Me	For My Caregiver
Monday	Monday
Tuesday	Tuesday
Wednesday	Wednesday
Thursday	Thursday
Friday	Friday
Saturday	Saturday
Sunday	Sunday

Body Diagram



Typical Week

	Monday	Tuesday	Wednesday	Thursday
Morning				
Afternoon				
Night				

Household Routines and Preferences

Household Routines and Preferences
e.g. Please wash your hands in the bathroom sink instead of the kitchen sink *e.g. Please leave the thermostat at 22℃*

Blank Calendar

Month: Year:

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

My Emergency Management Plan

911 Script	

Date of Completion	
Advanced Directive/Code Status	
Child's Name	
Date of Birth	

Parent/Guardian	
Signature/Consent	
Primary Language	
Emergency Contact	
Phone Numbers	

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My Emergency Management Plan (Page 2)

My Medical Providers	
Primary Care Provider	
Primary Care Emergency Contact	
Specialist Provider and Role	
Specialist Emergency Contact	
Anticipated/Preferred Emergency Room	
Anticipated/Preferred Hospital	

My Common Past Problems and Concerns	
Problem or Concern	
Past Helpful Testing	
Previous Recommendations	

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My Emergency Management Plan (Page 3)

My Lines, Appliances, Drains, Tubes

My Transportation Needs and Positioning Restrictions

My Pain Management Plan

My Diagnosis, Treatment, and Follow-Up Plan

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My Planned Hospital Stays (Page 2)

Hospitalization Date	
Location	
Reason for Admission	

My Questions for Team		
Role	Questions	Notes

My Plan of Care

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My Planned Hospital Stays (Page 3)

My Home Care Agency Contact

My Changes to Care and Schedule From Hospitalization (New Medications, Diagnosis, Interventions Needed)

My New Durable Medical Equipment (DME) Needs and Agency, If Applicable

My Notes About Discharge Plan and Follow-Up To-Dos

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Your Family Medical History

You can complete the highlighted fields on this form online and then print the form for easy reference. Only text that is visible on the form is printed; scrolled text will not print. Any text you enter into these fields will be cleared when you close the form; you cannot save it.

Health problems sometimes run in the family. That's why it's important to know as much as you can about the health of your birth family. This information can help your doctor provide better care.

Start with what you know, then ask your parents or other relatives for more information. It's a good idea to update this chart every year or so. Take a copy with you every time you see a new doctor so that he or she can keep it in your file.

Family member	**Name**	**Health problems (and approximate age when problem started or occurred)**	**If no longer living, cause of death (and age at death)**
My mother			
My father			
My sisters and brothers			

Family member	Name	Health problems (and approximate age when problem started or occurred)	If no longer living, cause of death (and age at death)
Mother's mother			
Mother's father			
Father's mother			
Father's father			
Others			

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Vital Signs Calendar

Month/Year: _____

Use this calendar template to track vital sings such as blood pressure, heart rate, respiratory rate, weight, pain, bowel movements, etc.

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Activities of Daily Living (ADL)

Last Updated: _____

The term, 'Activities of Daily Living' (ADL) refers to everyday personal activities. Examples include bathing, eating and drinking, and walking[1]. Use the chart below to track your ability to complete ADLs. This is important information to share with your healthcare providers to provide and plan care. It should also be updated over time as ADLs may change.

	No Help Needed	Some Help Needed	Complete Help Needed	Not Applicable
Example (Bathing)	***e.g. face and arms***	***e.g. rest of body***	***e.g. hair washing and back***	

	No Help Needed	Some Help Needed	Complete Help Needed	Not Applicable
Bathing or Showering				
Dressing				
Grooming				
Mouth Care				
Toileting				
Transferring Bed/Chair				
Walking				
Climbing Stairs				
Eating and Drinking				

[1] Adapted from: Senior Planning Services. (2013). *ADL/IADL Checklist*. Retrieved from: https://www.seniorplanningservices.com/files/2013/12/Santa-Barbara-ADL-IADL-Checklist.pdf

Instrumental Activities of Daily Living (IADL)

Last Updated: _____

The term 'Instrumental Activities of Daily Living' (IADL) refers to activities which allow a person to live independently[2]. Use the chart below to track ability to complete IADLs. This is important information to share with your healthcare providers to provide and plan care. It should also be updated over time as IADLs may change.

	No Help Needed	Some Help Needed	Complete Help Needed	Not Applicable
Example (Shopping)	***e.g. Make own list and visit store***	***e.g. Needs help finding items, loading in cart and paying***	***Shopping***	

	No Help Needed	Some Help Needed	Complete Help Needed	Not Applicable
Shopping				
Cooking				
Managing Medications				
Using a Phone				
Housework				
Laundry				
Transportation				
Managing Finances				

[2] Adapted from: Senior Planning Services. (n.d.). *ADL/IADL Checklist*. Retrieved from: https://www.seniorplanningservices.com/files/2013/12/Santa-Barbara-ADL-IADL-Checklist.pdf

world of printables

MEDICAL EXPENSE TRACKER

YEAR _____

MEDICAL SERVICES & VISITS

Date	Provider	Description	Amount	Insurance	Out-of-Pocket

TOTAL CHARGED

Total Insurance Paid:

Total Out-of-Pocket:

Total Charged:

NOTES

Insurance Information

Type:	
Provider:	
Policy #:	
Group ID:	
Expiration:	
Phone #:	
Website:	
Username:	
Password:	
Notes:	

Type:	
Provider:	
Policy #:	
Group ID:	
Expiration:	
Phone #:	
Website:	
Username:	
Password:	
Notes:	

Type:	
Provider:	
Policy #:	
Group ID:	
Expiration:	
Phone #:	
Website:	
Username:	
Password:	
Notes:	

Type:	
Provider:	
Policy #:	
Group ID:	
Expiration:	
Phone #:	
Website:	
Username:	
Password:	
Notes:	

Hospital Bag Worksheet

1. Check with your local hospital to see if they have any limits on what you can bring.
2. If there is a chance you will arrive by ambulance, include shoes and maybe an extra set of keys.
3. Most hospitals have extra blankets, pillows, toothbrushes, toothpaste, non-slip socks and shower wipes available. Pack only if you need/prefer certain brands.
4. Leave behind valuables.

What important info will I need?
Examples: ID, insurance info, credit card, living will, meds list, conditions list, power of attorney, medical binder

What will keep me healthy and calm?
Examples: extra medicine, medical devices or supplies, masks, hand sanitizer, ear plugs, sleep mask, cough drops, fidgets

What will keep me comfortable?
Examples: slippers, sleepwear, shower shoes, extra clothes, dirty clothes bag, inflatable neck pillow, comfort item

What will help me have good hygiene?
Examples: no rinse shampoo/dry shampoo, soap/body wash, toothbrush, toothpaste, body wipes, deodorant, hair ties, menstrual supplies, lotion, brush, lip balm

Hospital Bag Worksheet

What will keep me entertained?
Examples: headphones, phone/tablet, extra long charger, notebook and pen, puzzles, crosswords, book, colouring book

What other things will I need?
Examples: glasses, contacts, contact solution, money for vending machines, food seasoning, snacks if there's a long wait time

Who can bring what?
Think about: Am I bringing everything? What's critical vs things I can wait on? Can someone else bring the less critical items with them?

Notes:

Hospital Packing Checklist

Critical items

- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
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Less critical items

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Least critical items

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